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Educating Gastrointestinal Patients About the Benefits of Vaccination

Dr. Buch:
This is *GI Insights* on ReachMD, and I'm Dr. Peter Buch. Joining us today is Dr. Francis Farraye, who will be discussing an article he coauthored, titled "How to Implement a Successful Vaccination Program in Outpatient Gastroenterology Practices: A Focus on Patients with Inflammatory Bowel Disease and Chronic Liver Disease," which appeared in *Gastroenterology* in 2023. Dr. Farraye is a Professor of Medicine at the Mayo Clinic in Jacksonville, Florida, where he directs the Inflammatory Bowel Disease Center.

Welcome to the program, Dr. Farraye.

Dr. Farraye:
Thank you so very much for having me.

Dr. Buch:
It is a pleasure. I'm looking forward to our discussion. Let's dive right into your article, Dr. Farraye. What are the immunization rates in individuals with inflammatory bowel disease?

Dr. Farraye:
I'd like to report that this is an area that I've been interested in for close to 15 years now, and it really wasn't on the radar screen for gastroenterologists many years ago, but now with better understanding based on the medications we're using to treat patients with inflammatory bowel disease, I think this is certainly on the radar screen, and vaccination rates are going up across the board. As you might imagine, there are certain resistance to specific vaccines, but I think we're doing much better than we were 10 or 15 years ago.

Dr. Buch:
And what can we do to boost the numbers that are out there right now?

Dr. Farraye:
I think the first thing we need to do is have a frank discussion with patients. Some patients are concerned that vaccination may exacerbate their underlying inflammatory bowel disease, and there's good data, including a paper that we published two years ago, showing no increased risk of developing IBD flares after vaccination. The second thing we need to do is be honest with patients. I tell my patients that I'm up to date with my flu vaccine, and I'm old enough to have gotten the shingles vaccine. We do know that a physician, physician assistant, nurse practitioner recommendation for a vaccination goes a long way in convincing patients about the benefits of vaccination.

Dr. Buch:
And how can the patients fall through the system? That's a big problem that we're all faced with, correct?

Dr. Farraye:
I think the bottom line is you may have 20 minutes with a patient, and you might have 40 minutes with a patient, and you have lots of things that you need to address—how they're doing in terms of their symptoms, have they had their recent colonoscopy, what about their blood test, and vaccinations and other health maintenance issues—often are at the end of the appointment when there's no time, so there's got to be a way to bring it to the forefront.

Dr. Buch:
Really important. And can you walk us through the immunization schedule for patients with inflammatory bowel disease?

Dr. Farraye:

Sure. So the first thing the audience needs to know is that patients with inflammatory bowel disease have an increased risk of developing infections, and some, but not all, are vaccine preventable. Now some of this has to be related to the medications we use. And we know that as many as 70 percent of patients with ulcerative colitis or Crohn's disease will be on immunosuppressive therapy at some point during their treatment course, and so it's best to try to address vaccines before they're immunosuppressed because A, once they're immunosuppressed, they're at increased risk, and B, our vaccines work better in the nonimmunocompromised patients.

Dr. Buch:
And if physicians want to look at a comprehensive list, all they have to do is look at your article, which appeared in *Gastroenterology* in 2023. Pretty comprehensive.

Dr. Farraye:
Yeah. I think that you can certainly look at something that we published, but another fantastic resource for the internist or gastroenterologist or hepatologist are the ACIP recommendations. They're published every spring in the *Annals of Internal Medicine*, and these are completely thorough and will go over the vaccines. They'll break it down by age, and they'll also break it down by specific disease, so you can look at individuals who are 19 to 59, and at the same time, they'll also have a section looking at immunocompromised patients that would include our patients with ulcerative colitis and Crohn's disease.

Dr. Buch:
Perfect. So let's turn our attention now to implementing a vaccination program. What are the steps needed to be successful?

Dr. Farraye:
First thing is to recognize that vaccinations are part of health maintenance for patients with ulcerative colitis and Crohn's disease. The second ideally, would be to have a vaccine champion, and that could be one of the nurses who see patients before or after the office visit so that the physician, nurse practitioner, or PA has more time to talk about managing their diseases. We have Epic in our system, and Epic has checklists that you can create. There are checklists from the Crohn's & Colitis Foundation, from an organization called Cornerstones, and you could put these in your EMR and have a checklist to remind yourself about the vaccines that are needed. But the first thing is to recognize that they're important and that we're keeping our patients safe by implementing the vaccination program.

Trying to implement an immunization program in a practice can be challenging. Don't forget that you can simply send your patient to their local pharmacy with a prescription. The pharmacies here in the United States often carry between 12 and 15 different vaccines. They can run a claim. The patient will know that the claim for the vaccine is going to be paid for. And as you know, some vaccines are covered by the Federal Government. And that patient can then get their vaccine even if you don't have the ability to administer the vaccine in your office.

Dr. Buch:
And moving on from there, should we ever obtain antibody levels after immunization?

Dr. Farraye:
So this is a bit of a controversial topic. In our 2017 article that was published in *The American Journal of Gastroenterology* on preventive healthcare in patients with inflammatory bowel disease, we did recommend to check hepatitis B serology in patients who are not immune after receiving vaccination, and the reason to do that would be some patients who are on immunosuppressive therapy may not mount a response to standard vaccination, and so they may need additional vaccines. But as you know, there's no antibody to test after the shingles vaccine, the COVID vaccine, and routine care influenza vaccine. So other than for hepatitis B, there's no antibodies that I typically check.

Dr. Buch:
Thank you. For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Francis Farraye about vaccination in inflammatory bowel disease.

Dr. Farraye, what should we know about immunization in households of patients with inflammatory bowel disease?

Dr. Farraye:
That's also a very important question. So just think of the situation where you're the mother or father of a 16-year-old who has Crohn's disease and is on therapy that is immunosuppressing them. Well, you want to be up to date on your vaccines so that you don't bring home something that could potentially affect the household member. That's called a cocoon strategy, and that strategy makes very good sense.

Now the other point we should know is that there are just very few live vaccines that you might need as an adult, and one of them could be the intranasal influenza vaccine, which is live. And so I would not want to have a family member of an immunocompromised patient

receive the intranasal live influenza vaccine. And that's a vaccine that's contraindicated in patients who are immunocompromised. For the most part, we do not give live vaccines to those patients who are on highly immunosuppressive therapies.

Dr. Buch:
And that's a perfect segue to my next question. How do you approach a patient already on immunosuppression whose live vaccine immunization is incomplete?

Dr. Farraye:
Well, the first question is which vaccine are we talking about? So you have to realize—you asked the question earlier about antibody testing—so we do know that some of the commercially available antibodies, for example, against measles or mumps or chicken pox, are not particularly sensitive. So what the ACIP recommends is that if there is a history of having chicken pox, for example, or a history of being immunized, don't check the antibody. Just assume that they're immune because of the sensitivity of the test.

Now there might be rare scenarios, for example, someone who's going to Africa that needs yellow fever vaccine, which is a live vaccine. In a situation like that, I actually defer to my colleagues in infectious disease or traveler's clinic because of the nuances. The last thing you want to do is have to stop the immunosuppressive therapy that is keeping their inflammatory bowel disease in remission, and that's another case in point why you want to make sure that patients are up to date on all their vaccines prior to initiating immunosuppressive therapy.

Dr. Buch:
Thank you. Before we conclude our discussion, are there any additional takeaways from your article that you would like to share with our audience?

Dr. Farraye:
I think that it's quite important that you think of the common entity, so annual influenza vaccine. The ACIP has now made a new recommendation that anyone 19 and older who's immunosuppressed now or at risk for immunosuppression is eligible to receive the shingles vaccine. The live vaccine is no longer available. Think about RSV. We now know that RSV is just as common as influenza, and we just published a paper that shows an increased risk of RSV infection in patients with ulcerative colitis and Crohn's disease. Hepatitis B testing should be universal, and if you're not immune, you should be immunized. And then obviously we can have a separate talk about COVID vaccines. I do want to remind people that even if you received the series back in '21 or 2022, you are at increased risk because of the Omicron strain, and I would recommend receiving an Omicron monovalent vaccine, and that's the one that became available after September 2023.

Dr. Buch:
What an important review on vaccination in GI patients. I want to thank my guest, Dr. Francis Farraye, for sharing his insights.

Dr. Farraye, thanks so very much for joining us today.

Dr. Farraye:
Thank you so much as well.

Dr. Buch:
For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit *GI Insights* on ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening, and looking forward to learning with you next time.